2017-08-22

"From the edge of the abyss to the foot of the rainbow Narrating a journey of mental health recovery" the process of a wounded researcher

Robertson, SJ

Qualitative Report

The Qualitative Report

Volume 22 | Number 8 How To Article 14

8-22-2017

"From the Edge of the Abyss to the Foot of the Rainbow – Narrating a Journey of Mental Health Recovery" The Process of a Wounded Researcher

Samantha J. Robertson
University of Southampton, UK, sam.recovery@virginmedia.com

Diane Carpenter
University of Plymouth, UK, diane.carpenter@plymouth.ac.uk

Maggie Donovan-Hall
University of Southampton, UK, mh699@soton.ac.uk

"From the Edge of the Abyss to the Foot of the Rainbow – Narrating a Journey of Mental Health Recovery" The Process of a Wounded Researcher

Abstract

In the UK, mental health service users are asked to "tell their stories" within clinical settings as a tool for diagnosis, formulation and treatment plans. Retelling, reliving and reflecting on traumatic and distressing experiences is not a benign activity. Yet the process of reframing lived experience within a personal narrative could support the development of: a more positive identity; self-management skills and improved social connections (Slade, 2009) and therefore contribute to mental health recovery. This is an exploration of my process as a wounded researcher in the development of a version of my narrative as an autoethnography. I developed a series of 54 vignettes that described memories of my lived experience. To start, I used memorable quotes - the voices of others within my narrative. Developing and analyzing my autoethnography was visceral. It highlighted aspects of my process (and the likely process of others) and raised many unresolved dilemmas. For example: what was left out or left unsaid and the issue of "narrative truth" (Craib, 2004); reordering the vignettes for coherence; the role of relational ethics; and the impact on my identity of this difficult on-going process. It impacted on my mental health, but it has been a crucial part of my recovery.

Keywords

Autoethnography, Personal Narrative Recovery, Mental Health, Service User Research and Relational Ethics

Acknowledgements

My PhD Supervisors: Dr Diane Carpenter - University of Plymouth Dr Margaret Donovan-Hall - University of Southampton

The Qualitative Report 2017 Volume 22, Number 8, How To Article 2, 2296-2307

"From the Edge of the Abyss to the Foot of the Rainbow – Narrating a Journey of Mental Health Recovery" The Process of a Wounded Researcher

Samantha J. Robertson
University of Southampton, Southampton, England

Diane Carpenter
University of Plymouth, UK

Maggie Donovan-Hall
University of Southampton, UK

In the UK, mental health service users are asked to "tell their stories" within clinical settings as a tool for diagnosis, formulation and treatment plans. Retelling, reliving and reflecting on traumatic and distressing experiences is not a benign activity. Yet the process of reframing lived experience within a personal narrative could support the development of: a more positive identity; self-management skills and improved social connections (Slade, 2009) and therefore contribute to mental health recovery. This is an exploration of my process as a wounded researcher in the development of a version of my narrative as an autoethnography. I developed a series of 54 vignettes that described memories of my lived experience. To start, I used memorable quotes - the voices of others within my narrative. Developing and analyzing my autoethnography was visceral. It highlighted aspects of my process (and the likely process of others) and raised many unresolved dilemmas. For example: what was left out or left unsaid and the issue of "narrative truth" (Craib, 2004); reordering the vignettes for coherence; the role of relational ethics; and the impact on my identity of this difficult on-going process. It impacted on my mental health, but it has been a crucial part of my recovery. Keywords: Autoethnography, Personal Narrative Recovery, Mental Health, Service User Research and Relational Ethics

> *Autoethnography is an approach to research and writing that seeks to describe and systematically analyse (graphy) personal experience (auto) in order to understand cultural experience (ethno).* (Ellis, Adams, & Bochner, 2011, p. 1)

Ellis et al. (2011, p. 2) suggested that "as a method, autoethnography combines characteristics of autobiography and ethnography." Autoethnography implies that a narrative is being used for a purpose beyond simply telling a story. In doing autoethnography, there is a significant element of reflection and reviewing lived experience: using hindsight; "epiphanies" or times of "existential crises" (Ellis, 2009).

The process of autoethnography contextualises personal experiences within existing cultural practices and shared experiences. This may support better understanding for both insiders (cultural members) and outsiders (cultural strangers; Ellis et al., 2011).

Within mental health services, service users are continually asked to tell their stories (often repeatedly) so that a diagnosis, a formulation or a treatment plan can be determined. The term "story" is often used rather than "narrative." Increasingly, some service users (me, for

example) are being asked to share our recovery narratives with professionals at conferences and for teaching and training purposes – to offer testimonials (Frank, 1995) of our individual recovery journeys. We are held up as beacons of hope and as examples of the system "getting it right." One might question "for whose benefit are we asked to tell our narratives?" Retelling, reliving and reflecting on traumatic and distressing experiences is not a benign activity.

My Position as Researcher

I am a "wounded" researcher with an insider perspective. As a long-term mental health service user, I have personal experience receiving care in both primary and secondary (In-patient, day hospitals, hospital at home and community) services. I have also used day care within the third sector. Within my mental health "career" (Kleinman, 1988) I have received individual, group, creative art and medication therapy. Alongside this (and at times despite these services), I have been on "my personal recovery journey" (Pilgrim & McCranie, 2013) – an individual process of learning and growth. As a result, I am more self-aware, accepting and autonomous. I have become my own agent and decision-maker in my own recovery. I am an experienced advisory teacher, mental health trainer, consultant and mental health activist.

This paper is the result of further developing my personal narrative as an autoethnography, which is titled, "*From the Edge of the Abyss to the Foot of the Rainbow – Narrating a Journey of Mental Health Recovery."* This paper is a reflection of the challenges and my process as a "wounded researcher" (Romanyshyn, 2007).

My autoethnography was the first phase of my self-funded PhD research – "What does the process of developing a personal narrative involve and how does it contribute to mental health recovery?" Phase 2 explored the process of developing a personal narrative using Participatory Action Research (PAR). Focus groups with service users who had developed their narratives were used to discuss their process (le May & Lathlean, 2001; Meyer, 2010). Using the themes generated (Braun & Clarke, 2006) in Phases 1 and 2, Phase 3 involved developing a peer-led Personal Narrative Workshop Programme for mental health service users.

Mental Health and the Value of Narrative Development

Bruner (1987) suggested within a social world, narrative is dominant – it is a sense and world-making process. Narratives can be temporal, multi-voiced social constructions, which are dependent on individual values and cultural practices (Moen, 2006). Narrative reflects the interaction of and the social and cultural assumptions of the teller and the audience, such that there is no one "true" narrative but a range of alternative possibilities (Bruner, 1987).

In his Personal Recovery Framework, Slade (2009) described four tasks of recovery: develop a positive identity; reframe the mental illness; develop self-management; and develop valued social roles. Established recovery tools such as Wellness Recovery Action Plan (Copeland, 2013) and Recovery Star (Mental Health Providers Forum, 2013) are widely used in developing self-management. Alongside developing community links, these tools also promote improving and gaining valued social roles. There are fewer interventions (other than one to one therapy) that support individuals to reframe their experiences (and thus develop positive identities). Developing a personal narrative is one way of framing the illness and reframing the experiences.

Reframing within the development of the personal narrative can allow flexibility (Moen, 2006) – that is, the narrative is continually constructed and revised depending on time and audience. Within the context of mental health recovery, Kerr, Crowe, and Oades (2013) suggested a meaning-making model that developing a personal narrative could be viewed as a "transitional process" or a transformational process towards living a meaningful life. This view

seems to support other recovery models and frameworks (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Reframing allows the individual to contextualise their mental illness experiences and can provide sense to otherwise senseless experiences (Frank, 1995).

This can lead to the development of a more positive identity, with the growing ability of the individual to distinguish between the "me/it" (Slade, 2009). In the early stages of recovery there can be a sense of overwhelming chaos and lack of control and understanding. The illness "it" (and often the diagnosis) can be the totality of the individual's existence and identity (e.g., "I am a 'depressive'"). Frank (1995) and Kleinman (1988) added that people could be stuck within certain illness narratives. Reframing and the integration of what is happening with new understanding and insight can lead to the illness identity becoming only one aspect of the individual, (i.e., "I have depression"). Narrative development could possibly provide a way forward for the individual.

Method and Results

Autoethnographic Vignettes

I developed a series of 54 vignettes that described memories of my lived experience. A vignette is "a short piece of writing that expresses the typical characteristics of something or someone" (Cambridge Dictionaries Online, 2016). The vignette as a "short and incomplete" snapshot seemed appropriate as much of my mental health experiences felt chaotic, piece-meal and lacking any sense of coherence. Each vignette was a visceral snapshot that had a huge impact on my life and my sense of self. As a starting point, I used memorable quotes and statements - essentially the voice of others within my narrative.

Fig. 1: Freedom **"Zenos Frudakis, Sculptor ©2000"**

This public sculpture "Freedom" (Fig. 1; Frudakis, 2000) reflects my journey of mental health recovery. It represents the concept of recovery (Anthony, 1993; Scottish Recovery Network, 2013) – the idea of living a meaningful life whilst dealing with the on-going symptoms and challenges of long-term mental health issues. Recovery in this context is different from recovery within the traditional loci of the psychiatric (and physical health) medical model, where recovery is essentially returning to a "pre-illness" state (Davidson, Sells, Sangster, & O'Connell, 2007; Whitwell, 2001).

My official introduction to the world of mental health was in 1996. For many years there was a sense of "nothingness," chaos (Frank, 1995), unknowing and the unknowable. Surviving from moment to moment - an overwhelming sense of disability, lack of control and disconnection with self and others (Spaniol, Wewiorski, Gagne, & Anthony, 2002). I experienced a total loss of self-hood; I merged with the wall. Experiences, emotions and

fractured relationships relived within fourteen vignettes in my autoethnography, entitled *"The Hopeless Narratives."*

My mental health recovery has been a 20-year on-going, non-linear journey (Bird, Leamy, Le Boutillier, Williams, & Slade, 2014; Leamy et al., 2011). There were/are periods of: wellness and illness; being in the world and being hospitalised; success and failure; relationships and social isolation; extreme tiredness and mania; working and idleness. These juxtapositions continue - an underlying sense of "all-or nothing" living. There is still no certainty, yet there is a sense of growth and movement forward – benefitting from therapeutic input and tools learnt. I have emerged from the wall, reaching out, accepting help and regaining my agency. Nineteen vignettes, *"The Long Assent Narratives"* reflect the work and struggles experienced as I began to regain some sense of self. The final 19 vignettes, *"The Thriving Not Surviving Narratives"* describe the complete emergence from the wall. These vignettes are reflective, but with a forward momentum.

Before I started to write any vignettes, my supervisors asked what my plans were. What structure did I think that I would use? At the time, I resisted their academic need to pin the process down, to know what I was going to achieve before I started. I did not know how it would turn out or what it would include. I accepted this ambivalence. In retrospect, the organic nature of how the vignettes developed was crucial and in a sense reflected the non-linear and uncertain nature of my recovery journey.

The vignettes were written in no particular order, although Vignette 12 (Box 1) was the starting point. It was the moment when I realised that something was wrong but lacking the awareness and insight into what.

Box 1: Extract: Vignette 12. "I don't know who you are anymore!" (June, 1996)

We bump into each other awkwardly. In the doorway of our empty classroom. Miles scurries out, with the kettle in his hand. We look at each other. We have nothing to say. No smile or laugh at the absurdity of the moment. The kettle in his hand says it all. Miles needs to escape. I say nothing. The moment elongates. Looking down at the kettle, Miles says quietly…

Miles - I don't know who you are anymore.

He walks away. I sit in our cubbyhole of an office - alone bereaved racing thoughts no thoughts despairing empty silenced alone alone. The bell rings for afternoon school. Feeling nothing feeling everything. An automaton teaches afternoon classes watches the performance from some place else. The shell rushes off at a snail's pace to pick up my son from where he was left that morning. No looking back.

Before my maternity leave lunchtimes were spent in our office together. Preparation for classes not yet taught. Marking. Planning - Ofsted was on the horizon. Seeing students. Chatting. Gossiping. Talking football. Content in our silence too. We were a team – had been for three years. Miles was my boss and he was my friend. We were tight. We shared a vision and a passion for our subject. We were frontiersmen, innovative and ambitious. I was fast-tracked, a spotlight over my head. I would go far. Everyone said so. Before my maternity leave.

Vignette 12 was a snapshot of my descent into unknowing despair and disconnection. From this vignette, there was another and another. One memory sparked off the next. They spanned my lifetime. It was necessary to jot down ideas before they were lost. The vignettes developed as a chain reaction, until I thought that I was done.

As part of the process, I asked my husband to review the vignettes (he had lived through most of them with me). I read him the vignette titles. He said that there were no positive vignettes. I had a choice - I could have said that the vignettes were complete. On reflection, I realised that if this was a mental health recovery autoethnography, it was not a fair reflection of my life experiences post-1996. It highlighted how difficult it was for me to consider the

positives in my life - an example of the importance of reframing, in order to regain a more positive sense of self (Slade, 2009). As a result, I drew a time-line – a line across the middle of a piece of A3 paper. I started at 1996. Below the line, I put all the "rubbish" – the mental health difficulties, crises and struggles (the vignettes already written). Above, I put the "good stuff," the happy times, the successes, the holidays etc. I needed to write about the "above the line" experiences. This was extremely hard. It was a much more conscious process. These vignettes (e.g., Vignette 49. *The "Old Me"* Box 3) did not flow in the same way as the "below the line" vignettes had. I had to search for the right words. Reframing was difficult! However, the reflection and reframing that I did as a result of developing these positive vignettes allowed me to consider the lessons that I have learnt over my recovery journey and led to a number of epiphanies such as Vignette 47. *"You've found your voice" (July 2013 After leaving NHS Mental Health Trust).* Reframing had supported my renewed agency.

Reordering Vignettes for Coherence

The vignettes were written in no particular time order. They made sense to me but for others, might be seen as a jumbled mess, difficult to follow with no underlying thread. This posed some important questions: what is the purpose of an autoethnography and who is this narrative for? Writing as part of my PhD process and the fact that it was important for me to reframe and share my narrative (Macias, 2009; Scottish Recovery Network, 2011), to reconnect and to provoke audience debate - it needed some semblance of structure and temporal order. I rearranged and reordered the vignettes into coherent themes (Burnell, Hunt, & Coleman, 2009; Kempson & Murdock, 2010; Saavedra, 2010).

Box 2: Vignette 29. "You've had your moan, now let's get to work!" (c 2005)

It's a warm summers day. We are sitting in the garden. I am on a lounger and Jim sits next to me. He listens without interruption. He listens to my woes, my angst, my distress. He is with me in this moment. He is with me in my distress. I pause for breath, waiting for a response, for feedback for the usual platitudes – the usual soothing saccharine comments that I am conditioned to receive but not believe. I need the comments so that I can throw them back in his face. It will not get better! I don't want to give it any more xxxxxxx time! Yadda, yadda, yadda. He sits quietly, aware of the conversation going on in my head, giving me space. Not adding to it. He gives me time. I'm xxxxxx off with him. He is meant to help me. Yet he just sits, quietly serene.

He sits forward, closing in on me, invading my space. Ready to speak at last.

Jim – right you've had your moan, now it is time to work

I look at him incredulously. How ***** dare him. In my head – my first reaction – ****off Jim. I don't need you. You are like the rest of them. A bunch of *******. I pause. I take a breath. Out loud I say

Me - ok

I didn't know it at the time but this was a turning point – an epiphany. I was being offered the choice to move forward with my recovery. I chose to do so, although I didn't know it at the time.

Discussion

Reflections on my Process

As a service user and the autoethnography author, I could be described as a vulnerable adult too. At the outset, I was aware that I would be writing about traumatic experiences. I thought that the autoethnographic process would be a simple and straightforward one. I was

an "old hand" at developing my narrative with different emphases for different purposes and audiences, for example, a focus on mental health and family, stigma issues, power differentials and using recovery tools. I had also developed and run training course to facilitate other service users to develop their recovery narratives for the purposes of the NHS Trust that I worked for. I thought that developing and sharing my narrative was a benign process. However, I found both the writing and analysis were incredibly hard. It was a visceral experience – evoking bodily sensations, my lived environment, physical interactions and emotional distress (Ellis, 2009; Poursanidou, 2015). In order to reflect on the "what I have learnt" aspects and epiphanies, I had to re-experience the trauma. I wrote in a darkened room, worked punitively and had disregarded any notion of self-care towards the wounded storyteller (Poursanidou, 2015). I became increasingly disconnected from the world, even when I was not writing. I was repeating behaviours that characterised and contributed to my mental health difficulties. I was becoming unwell.

What Was Left Out or Left Unsaid

Having difficulty including positive content in my autoethnography raises the issue of narrative truth. Unlike Bruner (1987) who talked about the importance of rightness, intention and coverage, Craib (2004) argued that bad faith narratives were possible - narratives are not sacred. Hyvarinen (2008) commented that "narrativity always carries with it some sort of tendency to revision" (p. 266), with the subsequent reflection the essence of the reframing process.

Retrospective narratives (e.g., Frank's (1995) quest or testimonial narratives) can give significance and validity to life experiences that are not necessarily truthful accounts. In a critique of Kleinman (1988) and Frank (1995), Atkinson (1997) suggested that a recuperative narrative without any accompanying social analysis action (as in autoethnography) was a wasted opportunity. Atkinson argued that a choice should be made regarding narrative function - the revelatory, emancipatory and therapeutic power of the narrative for the individual and audience or the narrative as a more academically rigorous socially constructed critique.

This either/all argument is not necessarily relevant to the individual developing their personal narrative. Within the vignettes there are examples of extremely personal experiences which represent a life lived, for example, Vignette 4 *"All that I have invested in you" Part 1 (1976-79)* and Vignette 8 *"Don't worry she doesn't like anyone" (January 1985)*. Both are about my mother and her overwhelming need to control every aspect of my young life. Perhaps the benefit of these vignettes to others include the opportunity for the audience to relate - to draw parallels with their own lives; and as an example for individuals who have been marginalized and silenced, for example, mental health service users can have a voice. Other vignettes reflect experiences that were more political and represent social commentaries for example, power differentials and stigma within mental health, for example, Vignette 21 *"If you don't behave, I will change your diagnosis to BPD" (private psychiatric hospital, 2013)* and Vignette 39 *"You are a service user not a professional"* (a Recovery College, 2013). Many vignettes were written in messy texts (Short, Grant, & Clarke, 2007; Short, Turner, & Grant, 2013), often without punctuation, with profanity and as a stream of consciousness (Csikzentmihalyi, 1997). Interestingly the later, "positive" vignettes were written in more Standard English with carefully constructed sentences. Less emotionally but more rationally written. Perhaps this difference reflects the difficulty that I had producing these "successful" vignettes.

Impact on My Identity

Box 3: Vignette 49. "The Old Sam"

I often prefixed sentences with "the old Sam" suggesting that the old one would have done things differently. Someone once asked me, why I used this phrase so much. I had to think, to analyse to consider…

I was telling people that I am doing things differently – even telling people who didn't know the old Sam. I needed to remind myself that I was doing things differently. It is incredibly important and at times life-saving that I use the tools that I have developed in all the years of therapy – it makes all the wasted years worthwhile – to have gone through all the shit and not learnt anything – they might as well shoot me now. I acknowledge that I am intolerant of people who do not learn and apply to change their lives for the better – always cast as the victim, playing the victim role and taking a bow. I suppose that I need to acknowledge to myself and others that change takes effort and energy. Nearly 20 years into this sentence and the 'cant do scary impossible, weak, dependent – are often still my default positions. I have to work to turn it around. The old Sam – without the benefit of insight and tools - would have reacted and behaved differently, punitively and gravely – perpetuating disconnection and self-hatred. The new Sam said, did and felt differently. I suppose part of me was also showing off that I was doing things better, more appropriately, less toddler-like and that people were also benefitting as a result. I needed to be continually reminded of how far I had come. To move forward, to thrive and not just survive. The old Sam was surviving and often barely that. The new Sam is out in the world living, contributing, shouting from the rooftops. Yah!

I say the "old Sam" less often out loud, but I have a wry internal grin when I think it. Oh I'm growing into an adult!

"Narrative truth" criticism appeared to underplay the possible therapeutic role of narrative, the sense that individuals share narratives in order to understand their emotions and to try to make sense of their experiences. Within any given cultural context, illness had physiological, psychological and social meaning, which have significant implications for an individual's sense of self and identity (Kleinman, 1988). Although the illness experience is unique, Kleinman (1988) proposed that living with chronic illness always involved: a sense of loss and grief; uncertainty; economic and temporal loss; and an element of shame and being hidden. All of these themes are described in my vignettes. The meanings that an individual ascribed to their illness, was essentially an attempt to restore order and understanding.

There is the possibility that rather than reflecting the illness experience, the personal narrative may contribute to it (Kleinman, 1988). If the narrative contributes negatively to the illness experience it is unlikely to support mental health recovery. Factors such as: the medical model environment (perceived power/powerlessness); illness chronicity; type and "acceptability" of illness (e.g., schizophrenia or cancer); public and personal stigma (Goffman, 1963); employment and social inclusion; and relationships and roles that are played (the "patient" or the "victim") may contribute to the illness narrative.

For others (including me), developing a personal narrative may contribute to breaking free from the "illness or sick role." Narratives could help repair the damage done by illness and the environment of illness – "they need to become storytellers in order to recover the voices that illness and it's treatment often takes away" (Frank, 1995, p. xii). "The way out of the narrative wreck is telling stories" (p. 55). Self and identity could be rediscovered through narrative. If illness experience dislocates identity (our past does not predict our present), narrative could have the potential for integration of the past, present and possible futures.

My autoethnography reflects this possibility: *Hopeless; One-Step Forward – One-Step Back; Moving Onwards and Upwards; Thriving not Surviving* with the key reframing process evident in the *Lessons Learnt – Doing Things Differently, Epiphanies and Moments* vignettes. Overall there is a sense of integration; a difficult life lived yet with hope for the future. The later reflective vignettes (although so hard to write) offer the hope, the sense of continued

movement forward with a more rounded positive identity. Vignette 45 *"I bet that you are borderline" (2011 work)*, whilst said as an insult was on reflection an epiphany because it allowed me to make sense of my on-going mental health challenges: continuous suicidal ideation; abandonment and disconnection issues; and often a sense of complete emptiness. Now I am able to understand and work with these distressing aspects of my life and put them into perspective for example, Vignette 52 *Getting back on the horse* (Box 4), Vignette 53 *"That is why we are so attracted to you" (January 2015)* and Vignette 54 *"You are an inspiration."* I am now able to think about who I am and acknowledge that I am more than my diagnosis!

Box 4: 52. Getting Back on The Horse

As I reflect on the time from 1996 – 2010, it is easier to concentrate on the horror, the despair, the sheer emptiness and waste – the black hole. It is easy to remind myself of the loss, the hopelessness – my constricted and constrained world. The mental patient – the nut job – the shirker, the lazy bitch… yadda, yadda, yadda. To relive these tortuous times in all their monochrome glory. Yet in this same time, I also achieved many things. I find it harder to remember or acknowledge these counterpoints. I had to be reminded by Don. As I think about them now, I am unable to put any of them into vignettes – only straightforward prose will do. A list of "didn't she do well," "not bad for a nutter" … It is either this or leave them out.

At the point of when I was at one of my lowest points – early in my mental illness journey, when I was the walking zombie, the bad mother, the cold wife, I did two things, which on reflection were two very important things, which positively changed the course of my life.

1. I began and completed a psychology degree with the Open University. I fell in love with psychology. It helped develop new skills in me but also accentuated existing difficulties. I was awarded a first-class degree and was a Bruner Prize winner – but I fought daily battles with being good enough to the point that I worked beyond the point of exhaustion and it precipitated a major breakdown.
2. I went back to teaching – working with young people but in a completely different way – holistically – working as an advisory teacher to support other teachers to work holistically with excluded young people.

Another important factor in my recovery has been by mental health activism and getting involved in running mental health services – essentially making a difference to the lives of others, which in itself has a profound effect on me. All done with small steps – a little bit of volunteering, a bit of managing services, a bit of directing and finally a paid, permanent job within the enemy camp [the NHS]. Now I am doing a PhD in activism.

This continual movement and getting involved, trying new things and taking risks supported me in regaining a sense of self. Tenuous at times but growing in strength and confidence, giving me a sense that I can do things and be successful. All is not lost. I may be a mental health service user, but I am so much more. I am not my diagnosis – well not all the time anyway! It's much harder to joke and make light of success or the good stuff, but it is there. My recovery journey is light and shade, ying and yang – but I have to work much harder to remember this!

It highlights the public and private persona thing again. At home, I am often in PJ's eating my dinner off a tray watching TV. I watch crap. I watch crime dramas. I watch blockbuster and subtitled art house movies. I avidly follow sport. Go to games, drink beer and swear with the best of them. I enjoy good food and Crunchies. I go and see comedy and opera. Gigging from Blondie to Andy Williams. I talk about philosophy and nonsense. I have high hopes and am happy to just be. Walking the dog with Don by the sea is wonderful. Bickering about a question on Never Mind The Buzzcocks with John Doe - priceless. Reconnecting with long lost friends – life-affirming. Unfriending those who add nothing – liberating. I am complex, mask wearing, open and increasingly authentic. It has to be worked at each and every day.

The Voices of Others in my Narratives

For me, developing a personal narrative is an on-going, piece-meal process. It involves reflection and possible revision (Ellis, 2009). Both the content and the process itself continually impact on my sense of self. I was used to sharing my "recovery story," yet I felt a tremendous burden of writing my autoethnography. This continues. This may have

implications for insider/service user research within critical autoethnography, when the research requires continual contact with deeply distressing material.

My narrative is also the narrative of identifiable others (family, friends, colleagues and mental health professionals). They are about relationships and interactions. Writing about shared experiences, even when written from a particular point of view could have significant implications to the on-going relationship. The status quo may be affected. Unconscious and invested power dynamics or ways of interaction may be questioned.

Each vignette begins from the voice of another – the headline quote – which ignited the memory or experience described within each vignette. Two of the key individuals in my autoethnography were my husband and son. Both gave consent to be included in my narrative. It is important to assume that anyone may read our published work (Ellis, 2009). My husband did not want a pseudonym, (it would have been difficult to anonymise him). Other people may read my autoethnography - how do I as the autoethnographer support him given the possible reaction of others? My son (who is not part of the mental health world) chose the pseudonym John Doe. We discussed how the name John Doe promoted interest, which a more neutral name (e.g., John) would not. He chose to remain John Doe. Whatever his chosen pseudonym, he would be still recognizable as my son.

I asked other family members to co-produce a shared narrative – to offer their interpretation and insight to often shared familial experiences. This was declined. Given this, do they now have the right to reply to my narrative? Can they choose not to be included? Could they be anonymised and/or fictionalised? These dilemmas are unresolved. At this point, I do not share with a wider audience, any vignettes that contain their voices. This emotional trauma continues. Developing my autoethnography has on-going effect on my sense of self and my mental well-being.

Writing about intimate others has implications. There needs to be careful consideration about how individuals' include others within our narratives and the possible effects of this. This may involve negotiating - taking the narrative back to the "storied others" and asking for comments (Ellis, 2009; Poursanidou, 2015), producing multiple-voiced narratives (McHugh, 2015), fictionalising the narrative (Campbell, 2015), mindful slippage (Medford, 2006) or writing and not sharing or publishing (Ellis, 2007; Poursanidou, 2015). There appeared to be no universal principle in writing about intimate others, other than "do no harm" (Ellis, 2007, p. 5). There are potential benefits to writing about intimate others but perhaps part of the reframing process may need to be an exploration around blame and guilt between the narrator and those storied.

This raised a number of relational ethical issues (Ellis, 2009) that were not covered by ethics approval procedures for this research. Because I was writing about myself, I did not need ethics approval for the autoethnographic phase. In writing my narrative and the subsequent thematic analysis (for this phase), I realised how "messy writing about intimate others" was (Ellis, 2009, p. 10), and continues to be. The boundaries (a sense on being an individual) that may be apparent between strangers are blurred and difficult to distinguish when lives are intertwined. I have written about intimate others with whom I have shared history; who may have contributed to difficult experiences; and with whom I have on-going relationships. Yet, in order to understand and reframe my lived-experience, it was necessary to write my narrative. Ellis (2009) suggested that writing about intimate others was a balance.

Conclusion

Developing my autoethnography has been like walking a tightrope over a precipice. It was scary and perhaps in many ways easier to stay where I was, but knowing that in reality

there was no choice. Growth, developing insight, agency and a more positive sense of self lay over on the other side.

The aim of my PhD research is to develop a peer-led personal narrative development workshop programme for mental health service users. Writing my autoethnography laid the fundamental foundation stone. In experiencing the visceral, emotional and on-going effects of this process first hand, I was able to reflect on the potential impact that developing a narrative may have on others. Factors such as: the need to have a dialogue around relational ethics; the importance of self-care and the need for the workshops to be in supportive environments have to be considered within the workshop design.

References

Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s, *Psychosocial Rehabilitation Journal*, *16*(4), 11-23.

Atkinson, P. (1997). Narrative turn or blind alley? In P. Atkinson & S. Delamont (Eds.), *Narrative methods* (Vol. 2, pp. 369-387). London, UK: Sage.

Bird, V., Leamy, M., Le Boutillier, C., Williams, J., & Slade, M. (2014). Fit for purpose? Validation of a conceptual framework for personal recovery with current mental health consumers. *Australian and New Zealand Journal of Psychiatry*, *48*(7), 644-653.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Bruner, J. (1987). Life as narrative. In P. Atkinson & S. Delamont (Eds.), *Narrative Perspectives* (Vol. 1, pp. 99-115). London, UK: Sage.

Burnell, K. J., Hunt, N., & Coleman, P. G. (2009). Developing a model of narrative analysis to investigate the role of social support in coping with traumatic war memories. *Narrative Inquiry*, *19*(1), 91-105.

Cambridge Dictionaries Online. (Ed.). (2016). *Cambridge dictionaries online*. Retrieved from www.dictionary.cambridge.org

Campbell, E. (2015, October). *Should I share my journal entry with you? An ethical dilemma faced by an experiential educator*. Paper presented at the 2nd British Autoethnography Conference, Aberdeen, Scotland.

Copeland, M. (2013). WRAP. Retrieved from http://mentalhealthrecovery.com/

Craib, I. (2004). Narratives as bad faith. In M. Andrews, S. Day Sclater, M. Rustin, C. Squire, & A. Treacher (Eds.), *The uses of narrative: Explorations in sociology, pyschology, and cultural studies* (pp. 64-71). New Brunswick, NJ: Transaction.

Csikzentmihalyi, M. (1997). *Finding flow: The psychology of engagement with everyday life*. New York, NY: Basic Books.

Davidson, L., Sells, D., Sangster, S., & O'Connell, M. (2007). Qualitative studies of recovery: What can we learn from the person? In R. O. Ralph & P. W. Corrigan (Eds.), *Recovery in mental illness: Broadening our understanding of wellness* (pp. 147-170). Washington, DC: American Psychological Association.

Ellis, C. (2007). Telling secrets, revealing lives: Relational ethics in research with intimate others. *Qualitative Inquiry*, *13*(1), 3-29.

Ellis, C. (2009). *Revision: Autoethnographic reflections on life and work*. Walnut Creek, CA: Left Coast Press Inc.

Ellis, C., Adams, T. E., & Bochner, A. P. (2011). Autoethnography: An overview. *FQS Forum: Qualitative Social Research*, *12*(1), 1-13.

Frank, A. W. (1995). *The wounder storyteller: Body, illness, and ethics*. Chicago, IL: The University of Chicago Press.

Frudakis, Z. (2000). *Freedom* [Sculpture]. Philadelphia, PA.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.

Hyvarinen, M. (2008). "Life as narrative" revisited. *Journal of Literature and the History of Ideas*, *6*(2), 261-277.

Kempson, D., & Murdock, V. (2010). Memory keepers: A narrative study on siblings never known. *Death Studies*, *34*(8), 738-756.

Kerr, D., Crowe, T., & Oades, L. (2013). The reconstruction of narrative identity during mental health recovery: A complex adaptive systems perspective. *Psychiatric Rehabilitation Journal*, *36*(2), 108-109.

Kleinman, A. (1988). *The illness narrative: Suffering healing and the human condition*. New York, NY: Basic Books.

le May, A., & Lathlean, J. (2001). Action research: A design with potential. *Nursing Times Research*, *6*(1), 502-509.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*(6), 445-452.

Macias, J. (2009). How can we approach to traumatic stories in psychosocial rehabilitation context. A case study of a patient of paranoid schizophrenia. *Salud Colectiva*, *5*(2), 225-235.

McHugh, N. (2015, October). *Friendship or manipulation: Research as a relational mindfield?* Paper presented at the 2nd British Autoethnography Conference, Aberdeen, Scotland.

Medford, K. (2006). Caught with a fake ID - Ethical questions about slippage in autoethnography. *Qualitative Inquiry*, *12*(5), 853-864.

Mental Health Providers Forum. (2013). *Recovery star.* Retrieved from http://mentalhealthpartnerships.com/resource/recovery-star/

Meyer, J. (2010). Action research. In K. Gerrish & A. Lacey (Eds.), *The research process in nursing* (6th ed., pp. 257-283). Oxford, UK: Wiley-Blackwell.

Moen, T. (2006). Reflections on the narrative research approach. *International Journal of Qualitative Methods*, *5*(4), 56-69.

Pilgrim, D., & McCranie, A. (2013). *Recovery and mental health: A critical sociological perspective*. Hampshire, UK: Palgrave MacMillan.

Poursanidou, D. (2015, October). *Using critical autoethnography in service user-led/survival mental health research: Methodological questions and ethical dilemmas*. Paper presented at the 2nd British Autoethnography Conference, Aberdeen, Scotland.

Romanyshyn, R. (2007). *The wounded researcher: Research with soul in mind*. New Orleans, LA: Spring Journal, Inc.

Saavedra, J. (2010). Quantitative criteria of narrative coherence and complexity in persons with paranoid schizophrenia. *Journal Of Nervous And Mental Disease*, *198*(5), 349-355.

Scottish Recovery Network. (2011). Narrative Follow-up Study. Retrieved from https://www.scottishrecovery.net/resources/?ss=Narrative+Follow-up+Study&x=0&y=0

Scottish Recovery Network. (2013). Home Page. Retrieved from https://www.scottishrecovery.net/

Short, N. P., Grant, A., & Clarke, L. (2007). Living in the borderlands; writing in the margins: An autoethnographic tale. *Journal of Psychiatric and Mental Health Nursing*, *14*(8), 771-782.

Short, N. P., Turner, L., & Grant, A. (Eds.). (2013). *Contemporary British autoethnography* (Vol. 9). Rotterdam, The Netherlands: Sense Publishers.

Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals.* New York, NY: Cambridge University Press.

Spaniol, L., Wewiorski, N., Gagne, C., & Anthony, W. (2002). The process of recovery from schizophrenia. *International Review of Psychiatry, 14*, 327-336.

Whitwell, D. (2001). Recovery as a medical myth. *Psychiatric Bulletin, 25*(2), 75.

Author Note

Samantha J. Robertson is a doctoral candidate in the Faculty of Health Sciences at the University of Southampton. She is a mental health service user, a psychiatric survivor and a mental health activist. She trains and consults (education, government and third sector) on mental health issues. Correspondence regarding this article can be addressed directly to: sam.recovery@virginmedia.com.

Dr Diane Carpenter is a lecturer in Mental Health Nursing at The University of Plymouth. Diane has a clinical background in Mental Health Nursing and has taught mental health nurses and other health and social care professionals in academic and clinical environments since 1986. Her doctorate, gained in 2010, focused on an examination of mental health care and treatment in Hampshire from 1845-1914; she has since supervised several PhD students. She served as a PhD Supervisor on this research. Correspondence regarding this article can be addressed directly to: diane.carpenter@plymouth.ac.uk.

Dr Maggie Donovan-Hall is an Associate Professor in the Faculty of Health Sciences as the University of Southampton. Maggie has a background in Health Psychology and has a mixed portfolio of teaching and researching within the field of psychosocial issues and healthcare. She has a particular interest in qualitative research methods and using flexible and creative methodological approaches. She served as a PhD Supervisor on this research. Correspondence regarding this article can be addressed directly to: mh699@soton.ac.uk.

Article Citation

Robertson, S. J., Carpenter, D., & Donovan-Hall, M. (2017). "From the edge of the abyss to the foot of the rainbow – Narrating a journey of mental health recovery." The Process of a Wounded Researcher. *The Qualitative Report, 22*(8), 2296-2307. Retrieved from http://nsuworks.nova.edu/tqr/vol22/iss8/14